Form#: CP 04
Owner: Compliance & Privacy

Request for Accounting of Non-Routine Disclosures

Patient Name: _____

Patient MRN: _____ Patient Date of Birth: _____

Patient Mailing Address: _____

_____

Date of Request: _____ Date of Service: _____

Name of Requestor if Different from Patient: _____

Phone number of Patient/Requestor: _____

Location: D Children's Hospital □Touro Infirmary [Other

D West Jefferson Hospital □New Orleans East Hospital

D University Medical Center □East Jefferson General Hospital

1. What is the time period for which you desire the accounting of disclosures? Note that the period cannot exceed 6 years.
From: _____ To: _____

2. Specify which organization(s) you seek an accounting of disclosures from:

_____

_____

3. The First accounting request within a 12-month period is provided free of charge. However, subsequent requests within a 12-month period will be charged an administrative handling fee. By signing below, I agree to pay all applicable fees.

_____ _____

Patient Signature Date

_____ _____

If Necessary, Signature of Patient's Representative Date

Relationship of Representative to Patient: _____

4. Submit this completed and signed form to the LCMC Health Compliance department via mail or email at the following address:

LCMC Health Compliance Department
1100 Poydras St. Suite 2500 New Orleans, LA 70163
compliance@lcmchealth.org